ELIGIBILITY FOR MEDICAL CARE

INSTRUCTIONS

1. Prepare this form in triplicate when:
   a. A DD Form 2, DD Form 2 (Ret), DD Form 1173, Form PHS-1866-1, or Form PHS-1866-3 (Ret) has been issued but is not in the beneficiary's possession at the time of treatment; and/or
   b. The DD Form 2, DD Form 2 (Ret), DD Form 1173, Form PHS-1866-1, or Form PHS-1866-3 (Ret) is expired or confiscated due to mutilation; and/or
   c. The beneficiary cannot demonstrate eligibility for medical care under the Defense Enrollment Eligibility Reporting System (DEERS) and requires emergent treatment. Note: Patients, requiring nonemergent treatment, who cannot demonstrate eligibility for medical care under DEERS are to be denied care unless a DEERS override is met.
2. At time of signing, patient or patient's sponsor must show positive identification.
3. Supply information for each item. Distribute as follows:
   a. Original to patient administration office or outpatient administration officer, as appropriate.
   b. Copy to patient's sponsor or patient.
   c. Place copy as uppermost form in Health Record, right side. (Remove when proof of eligibility is presented.)

Section 1 — *(MTF/DTF staff shall check one)*

- ☐ A valid identification card cannot be provided.
- ☐ Identification card is expired and/or mutilated.
- ☐ Patient has failed a DEERS check. Reason: _____

Section 2 — *(To be completed by the patient or sponsor)*

Name of Beneficiary	Age	Status
Sponsor's Name, Grade or Rate, Status, Service	SSN	
Sponsor's Duty Station (Home Address if Retired)	Telephone: Work	
	Home	
Clinic or Specialty Service Rendering Treatment	Date of Treatment	

I certify the beneficiary is eligible for medical and dental care at this facility. I understand that a valid identification card or a certified DD Form 1172 (Application for Uniformed Services Identification and Privilege Card) must be presented to the patient administration officer or outpatient administration officer, as appropriate, *within 30 days* from this date. Furthermore, I understand that if eligibility is not established within this 30-day period, I will be billed at the established rate for treatment rendered.

Signature of Sponsor, Adult Dependent, Patient, or Guardian	Date
Signature and Title of Witness	Date

Section 3 — *(Physician or provider shall check two)*

- ☐ Health care was provided
- ☐ Health care was not provided
- ☐ Care was emergent
- ☐ Care was nonemergent

Provider's Name and Rank *(Print or Type)*	SSN
Provider's Signature	Date

Section 4 — *(Patient Administration Officer (PAO) shall check one block)*

- ☐ Eligibility verified utilizing _____
- ☐ Eligibility not verified. Referred for billing action.

PAO's Name and Rank *(Print or Type)*	SSN
Patient Administration Officer's Signature	Date